STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN46992

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/29/11 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was determined to be of Type II (111)	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after September 28, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and resident rooms 301 to 306 and 324 to 326. The facility has a capacity of 100 and had a census of 47 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/07/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 roll down doors at the opening in the kitchen wall, a hazardous area, would self close	K0029	K 029 To ensure a potentially alleged hazardous area will be equipped with automatic release system to rolling fire door. The rolling fire door that serves as an opening through the dining room	09/28/2011

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	upon activation of the fire alarm system. This deficient practice could affect all residents in the main hall dining room. Findings include: Based on observation with the Maintenance Supervisor on 08/29/11 at 1:35 p.m., the main dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the corridor wall. There was a pass through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling fire door with a fusible link. Based on interview with Maintenance Supervisor at the time of observation, the rolling fire door does not close upon activation of the fire alarm. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1		and kitchen will be equipped to release upon activation of the fire alarm. Overhead door was notified and service call was scheduled.. All residents have the potential to be affected by the alleged deficient practice. The rolling fire door was equipped to release upon activation of the fire alarm. All staff was inserviced by maintenance on the release of rolling fire door upon activation of the fire alarm. No other areas was identified as having the potential to affect residents or staff. Rolling fire door is equipped to release upon activation of the fire alarm. Environmental and Safety CQI will be completed to ensure proper function and release of the rolling fire door upon activation of the fire alarm. All staff inserviced by maintenance on the release of rolling fire door upon activation of the fire alarm with pre/post test. Environmental Safety CQI will be completed by maintenance to ensure the rolling fire door will release upon activation of of the fire alarm to ensure proper functioning monthly. CQI will be reviewed after 6 months to ensure threshold and will be reviewed by CQI if not met. All staff inserviced on rolling fire door being equipped to release upon activation of the fire alarm by maintenance with pre/post test. The CQI team reviews the audits monthly and action plans are developed as needed to	

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	Central Supply rooms measuring over 50 square feet in size with combustibles was provided with a self closing device. This deficient practice was not in a resident care area but could affect any number of staff. Findings include: Based on observation with the Maintenance Supervisor on 08/29/11 at 1:15 p.m., the corridor door to the Central Supply room containing nursing supplies and cardboard boxes, measuring over 50 square feet in size, lacked a self closing device. Based on an interview with the Maintenance Supervisor at the time of observation, he confirmed the Central Supply room measured over fifty square feet. 3.1-19(b)		ensure continual compliance. 09/28/2011 To ensure a potentially hazard area will have an automatic self closure device installed on the door. For staff that could have the potential to be affected by the alleged deficient practice, an automatic door closure was immediately installed on the door. No residents were identified to be potentially affected. For potentially affected staff, an automatic self closure device was installed on the door by maintenance. All staff inserviced by maintenance on automatic self closure being applied to the door. All potentially hazardous area storage areas will have automatic self closure devices installed on the doors by maintenance. Environmental and Safety CQI will be completed to ensure all hazardous area doors will have functioning automatic self closure devices on the doors. All staff inserviced by maintenance on the installation and functioning of the automatic self door closures in potential hazardous areas. Environmental Safety CQI will be completed by maintenance to ensure all potentially hazardous areas have automatic self closure devices installed on the doors and ensure proper functioning weekly for 4 weeks then monthly for 3 months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by	

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			CQI if not met. All staff inserviced by maintenance on installation and functioning of automatic self closure devices installed on doors in potentially hazardous areas with pre/post test. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. 08/30/2011	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 4 first floor exit doors equipped with a magnetic locking system, remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires all exits be in compliance with Chapter 7. LSC 7.2.1.6.2(d) requires activation of the building fire protection signaling system shall automatically unlock the doors in the direction of egress and the doors should not relock when the audible alarms are silenced since the rest of the system is still actuated. This deficient practice could affect any residents evacuated through the main dining room exit. Findings include:	K0038	K 038 To ensure that first floor exit doors remain unlocked with activation of the building fire protective signaling system. For all residents having the potential to be affected, IEI was notified and system was repaired immediately. For all residents using the dining area having the potential to be affected, IEI was notified and system was repaired immediately. All exit doors were inspected for functioning and release with activation of the fire protective signal by maintenance. Environmental Safety and CQI will be completed to ensure functioning and release with activation of the fire protective signal. All staff inserviced by maintenance on the function and release with activation of the fire protection signal with pre/post test. Environmental Safety and CQI will be completed by maintenance to ensure functioning and release with activation of the fire protective signal weekly for 4 weeks then	08/30/2011

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	Based on an observation with the Maintenance Supervisor on 08/29/11 at 2:30 p.m., the main dining room exit door which was equipped with a magnetic locking system failed to remain unlocked when the fire alarm system was placed in silence mode. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		monthly for 3 months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI if not met. All staff inserviced on functioning and release with the activation of the fire protective signal by maintenance with pre/post test. CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. 08/30/2011	
K0047 SS=E	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Based on observation, record review and interview; the facility failed to ensure a continuously illuminated exit sign where the exit or way to reach the exit was not apparent was immediately visible for 1 of 4 ways to the exit. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect any residents evacuating through the service	K0047	K 047 To ensure that exit and directional signs are illuminated continuously. For all residents using the first floor area, having the potential to be affected by alleged practice, the illumination of the sign was repaired immediately. For all potential residents using the first floor, the exit/directional sign was repaired allowing illumination continuously. All exit/directional signs were checked for proper functioning by maintenance. No other findings. All exit signs will be checked for functioning to ensure proper functioning by maintenance. Environmental and Safety CQI will be completed to ensure all	09/07/2011

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	corridor in the event of an emergency. Findings include: Based on an observation with the Maintenance Supervisor on 08/29/11 at 2:20 p.m., there was no illuminated exit sign above the double doors leading to the service corridor. Based on review of the facility's first floor Evacuation Plan map mounted on the wall near the main entrance, the service hall is used for an emergency exit. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		exit/directional signs are functioning Maintenance and Housekeeping inserviced by ED on function of the exit/directional signs. Function of the exit/directional signs was added to the Preventative Maintenance Log. Environmental Safety CQI will be completed by maintenance to ensure all exit/directional signs are continuously illuminated twice weekly for 4 weeks then weekly for 4 weeks then monthly for 3 months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold and will be reviewed by CQI team if not met. Maintenance and Housekeeping inserviced by ED on proper functioning of exit/directional signs. Preventative Maintenance Log revised to include checking for proper functioning of the exit/directional signs. CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. 09/07/2011	
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 1. Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72 the National Fire	K0052	K 052 To ensure the fire alarm system trouble signal is to be destintive and descriptively annunciated. An annunciator panel for the fire alarm system was installed. To ensure when	09/28/2011

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	Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation with the Maintenance Supervisor on 08/29/11 at 1:12 p.m., the main fire alarm panel is located in the electrical/mechanical room located in the service hall which was not continually occupied therefore a trouble signal could not be heard in this location at all time. The facility does not have an annunciator panel for the fire alarm system. Based on an interview with the Maintenance Supervisor at the time of observation, the service hall is not occupied continuously. 3.1-19(b) 2. Based on observation and		automatic dialer is in trouble mode that a trouble alarm would be heard in an occupied area. Alarm was reinstalled For all residents, staff and visitors that could have been potentially affected by the alleged deficient practice,an annunciator panel for the fire alarm system on 3rd floor is being installed and alarm was reinstalled. All staff inserviced by maintenance on the annunciator panel and alarm in regards to automatic dialers. Annunciator panel and alarms to signal trouble is being installed on 3rd floor and is distinctive and descriptively annunciated. Preventative Maintenance log updated to monitor functioning of the annunciator panel and automatic dialer component to ensure they are distinctive and descriptively annunciated. Environmental and Safety CQI will be completed to ensure functioning and annunciation of annunciator and alarms panel. All staff inserviced by maintenance on annunciation and function of annunciator panel and alarms for automatic dialer trouble component. Environmental CQI will be completed by maintenance to ensure functioning and annunciation of the annunciator panel and alarm for trouble of the automatic dialer component weekly for 4 weeks then monthly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed	

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	interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants. Findings include: Based on an observation with Maintenance Supervisor on 08/29/11 at 2:21 p.m., when the automatic dialer component was placed in trouble from phone line failure for five minutes, a local trouble alarm was initiated. The dialer was located in the electrical/mechanical room located in the service hall which was not continually occupied therefore a trouble signal could not be heard in this location at all time. The trouble signal was not transmitted any other continuously occupied location. Based on an interview with the		CQI team if not met. All staffed inserviced by maintenance on functioning and annunciation of the annunciator panel and alarms indicating trouble of the automatic dialer component with pre/post test. CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. September 28, 2011	

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	Maintenance Supervisor at the time of observation, he remembered an alarm at the nurses' station, but due to recent remodeling he doesn't believe the alarm was reinstalled. 3.1-19(b)			
K0056 SS=D	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete coverage of the sprinkler system was provided for 1 of 1 water heater rooms and 1 of 1 Marketing Director's closets in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. This deficient practice was not in a resident care area but could affect any number	K0056	K 056 To ensure complete coverage of the sprinkler system in the water heater room and in Marketing Directors closet. For staff that could be potentially affected by the deficient practice, sprinkler system was installed in the closet of the marketing directors office by PIPE,INC.. The water heater room has sprinkler system present along back side of wall near piping. Water heater door is a fire rated door. Tag on door was cleaned off to expose	09/12/2011

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	of staff in the water heater room or near the Marketing Director's office. Findings include: a. Based on observation with the Maintenance Supervisor on 08/29/11 at 1:05 p.m., the water heater room was not provided with a sprinkler head. The water heater room was enclosed with block walls but the door was a nonrated hollow metal door. b. Based on observation with the Maintenance Supervisor on 08/29/11 at 1:45 p.m., the closet in the Marketing Director's office lacked a sprinkler head. These were acknowledged by the Maintenance Supervisor at the time of the observations. 3.1-19(b)		fire rating so that it was visible. Facility audited and no other areas identified. Sprinkler head was installed in marketing directors closet by PIPE,INC.. Water heater room has sprinkler heads present along back side of wall near piping. Water heater room door had tag on door cleaned off exposing fire rating so that it was visible. Facility conducted an audit for areas in the building lacking sprinkler heads, and lacking fire rated doors. No other areas affected. Housekeeping and maintenance inserviced on monitoring/presence of sprinkler heads, and doors for fire rating tags and avoidance obstruction with paint etc... Sprinkler head was installed by PIPE,INC.in marketing directors closet. Environmental Safety CQI will be completed by maintenance or designee to ensure complete coverage of sprinkler system in all areas and that fire rating tags on doors will not be obstructed with paint etc. weekly for 4 weeks then monthly for 3 months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI team if not met. Housekeeping and maintenance inserviced on monitoring/presence of sprinkler heads and avoiding obstructing fire rating tags on fire doors with paint etc. with pre/post test. The CQI team reviews the audits	

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			monthly and action plans are developed as needed to ensure continual compliance. September 12, 2011	
K0104 SS=F	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility fail to ensure 3 of 3 hall duct penetrations were provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affects all residents since all residents rooms are located on the second and third floors. Findings include: Based on observations with the Maintenance Supervisor on 08/29/11 from 1:50 p.m. to 1:59 p.m., smoke dampers were not installed in the two ventilation ducts that penetrated the smoke barrier wall on the third floor and one ventilation duct that penetrated the smoke barrier wall on the second floor. This was acknowledged by the Maintenance	K0104	K 104 To ensure that hall duct penetrations are provided with a smoke damper. For all residents, smoke dampers will be installed. All residents on floor 2 and floor 3 will not have the potential to be affected by the alleged deficient practice due to smoke dampers being installed in the ventilation ducts that penetrate the smoke barrier wall on floor 2 and floor 3. Ventilation ducts were inspected and no other findings. Smoke dampers will be installed in the ventilation ducts that penetrate the smoke barrier wall on floor 2 and floor 3. Monitoring for maintenance of the smoke dampers will be added to the preventative maintenance log. Smoke dampers will be maintained monthly for 6 months then CQI will be reviewed to ensure threshold, and will be reviewed by CQI team if not met. Monitoring for maintenance has been added to Preventative Maintenance Log. CQI team reviews the audits monthly and action plans are developed as needed to ensure continual	09/28/2011

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	Supervisor at the time of observations. 3.1-19(b)		compliance. 09/28/11	
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 2 of 2 areas used for transferring of oxygen were provided with continuous mechanical ventilation. This deficient practice could affect any resident in the third floor dining room and any staff in the second floor oxygen transferring room. Findings include: Based on an observations with the Maintenance Supervisor on	K0143	K 143 To ensure that areas used for transferring of oxygen is provided with continuous mechanical ventilation. The continuous mechanical ventilations broken driver belt was repaired by maintenance. Potential residents on floor 2 and floor 3 will not have the potential to be affected by the alleged deficient practice due to the continuous mechanical device being repaired. The continuous mechanical ventilation system was repaired by maintenance. Monitoring the	08/30/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	08/29/11 at 1:55 p.m., the mechanical ventilation was not operating in the oxygen transfilling/storage room on the third floor. Based on an interview with the Maintenance Supervisor at the time of observation, one mechanical vent motor controls the ventilation for the second and third floor oxygen transfilling rooms, therefore, the mechanical ventilation for the second floor oxygen transfilling room would not be in operation. 3.1-19(b)		function of the continuous mechanical ventilation system will be added to the preventative maintenance log. Environmental Safety CQI will be completed to ensure functioning of the continuous mechanical ventilation system. Monitoring the function of the continuous mechanical ventilation system will be added to the weekly preventative maintenance log. Environmental Safety CQI will be conducted monthly to ensure function of the continuous mechanical ventilation system. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI team if not met. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. 08/30/11	
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources	K0144	K 144 To ensure a letter confirming the reliability of natural gas and low probability of interruption of the natural gas service is available at the facility. A letter from NIPSCO will be available at the facility. All residents, staff and visitors will not have the potential to be affected by the alleged deficient practice due to the letter being of current date and has appropriate	09/12/2011

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	states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas		documentation present. A current letter was obtained from NIPSCO. Letter contains supporting statements of reliability and low probability of interruption of service. Letter will be reviewed annually for correct supporting statements. 09/12/2011	

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	delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview at the time of record review with the Maintenance Supervisor on 08/29/11 at 11:05 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on record review, the facility did have a letter from their natural gas provider (NIPSCO) dated March 11, 2009 but the letter did not include all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The letter			

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	lacked supporting statements of reliability of natural gas and low probability of interruption of the natural gas service. This was acknowledged by the Maintenance Supervisor during the time of record review. 3.1-19(b)			
K0147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 power strips was not used as a substitute for fixed wiring to provide power for medical equipment. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents in resident room 309. Findings include:	K0147	K 147 To ensure that power strips are not used to provide power to medical equipment. Power strips were removed and electrical outlets installed. Facility was audited for use of power strips with medical equipment. No other findings. Two residents will no longer be potentially affected by the practice due to the installation of electrical outlets. All staff inserviced that no power strips are not to be used to provide power to medical equipment. Electrical outlets were installed for use of medical equipment. All staff inserviced by maintenance that power strips can not be used for medical equipment. Environmental and	09/28/2011

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	Based on observation with the Maintenance Supervisor on 08/29/11 at 12:20 p.m., the following pieces of medical equipment in resident room 309 were supplied with electricity by power strip: a concentrator, a suction machine and a breathing treatment machine. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)		Safety CQI will be conducted by maintenance to ensure that power strips are not used to provide power to medical equipment weekly for 4 weeks, then monthly for 3 months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed by CQI team if not met. All staff inserviced by maintenance on not using power strips to provide power to medical equipment with pre/post test. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. 09/28/2011	